

**THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH**

36867

STATE FILE NUMBER

FILED NOV 4 1957

Registration District No. 274 Primary Registration District No. 3052 Registrar's No. 446

Doctor, coroner, etc. must use only standard nomenclature in item 18. No symptoms will be listed. All diseases in Part I must be casually related. Coroner cannot certify to a death due to natural causes.

300
1-56

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE
GILLESPIE FUNERAL HOME

1. PLACE OF DEATH a. COUNTY <u>Pettis</u> b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Sedalia Rest Home</u> Length of stay in 1b <u>Life</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Missouri</u> b. COUNTY <u>Pettis</u> c. CITY OR TOWN <u>Sedalia</u> Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> d. STREET ADDRESS (If outside, give location) <u>1003 E. 5th St.</u> Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>CLARA</u> Middle <u></u> Last <u>SHOEMAKER</u>				4. DATE OF DEATH Month <u>Oct.</u> Day <u>25</u> Year <u>1957</u>							
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 22, 1875</u>		9. AGE (In years last birthday) <u>82</u>		IF UNDER 1 YEAR Months <u></u> Days <u></u> IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (City and state or country) <u>Pilot Grove, Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>John Harrison Ellis</u>						14. MOTHER'S MAIDEN NAME <u>Mary Ellen Felch</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Edwin Shoemaker, 1509 E. 4th, Sedalia</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation secondary to Foreign Body</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. <u>in Trachea (Food Particle)</u> DUE TO (b) <u>Pseudo-Bulbar Paralysis</u> DUE TO (c) <u>331X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis with two CVA's previously</u>										INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u> <u>3 yrs</u>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Asphyxiation</u>								
20c. TIME OF INJURY Hour <u></u> a. m. <u></u> p. m. <u></u>			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>								
20e. PLACE OF INJURY (e. g., in or about home, farm, factory, street, office bldg., etc.) <u></u>			20f. CITY, TOWN, OR LOCATION <u></u>			COUNTY <u></u>			STATE <u></u>		
21. I attended the deceased from <u>1954</u> to <u>Present</u> and last saw her alive on <u>5/15/57</u> Death occurred at <u>5:47 p.m.</u> m on the date stated above; and to the best of my knowledge, from the causes stated.											
22a. SIGNATURE (Degree or title) <u>Thomas J. Hoptman, M.D.</u>						22b. ADDRESS <u>Sedalia, Mo</u>			22c. DATE SIGNED <u>10/25/57</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>Oct. 28, 1957</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Salem Cemetery</u>			23d. LOCATION (City, town, or county) (State) <u>Beaman, Missouri</u>			
24. FUNERAL DIRECTOR ADDRESS <u>D. W. Heckart, Sedalia, Mo.</u>						25. DATE RECD. BY LOCAL REG. <u>10-28-57</u>			26. REGISTRAR'S SIGNATURE <u>Frances Shelby</u>		

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by Student Embalmer No.
working under my personal supervision..

Student.....
Signature of Student Embalmer

Signed

Russell E Maag

Licensed Embalmer No. 480

P. O. Address

Sedalia, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (F
to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.